

be identified and successfully addressed. In the United States, the National Heart Attack Alert Program undertook an intensive review of delay and its causes, and adopted 30 minutes as a realistic goal for the administration of thrombolytic therapy for patients with a clear diagnosis of AMI.<sup>5</sup>

We believe that 30 minutes is a reasonable and realistic goal, which can be achieved for most patients. If the goal of 30 minutes cannot be achieved among some patients, there should be adequate reasons for the additional time. The fact that an emergency department is busy or crowded should not excuse the staff from providing prompt care.

We emphasize that most hospital delay is caused not by patient factors but by hospital factors. If hospitals set up a system to ensure that patients with a clear diagnosis of AMI can be treated within 30 minutes, then patients in whom the diagnosis is less clear will also benefit.

**Michael Shuster, MD, DABEM, FRCPC**  
Chair

Emergency Cardiac Care Coalition  
Heart and Stroke Foundation of Canada  
Emergency medicine  
Mineral Springs Hospital  
Banff, Alta.

**Garth Dickinson, MD, FRCPC**

President  
Canadian Association of Emergency  
Physicians  
Assistant professor  
Division of Emergency Medicine  
University of Ottawa  
Ottawa, Ont.

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### TOOLS FOR DETERMINING APPROPRIATENESS OF CARE

The article "Appropriateness in health care delivery: definitions, measurement and policy implications" (*Can Med Assoc J* 1996; 154: 321-328), by Drs. John N. Lavis and Geoffrey M. Anderson, is a major contribution to the way we think about appropriateness of care in Canada. It has important implications for how we evaluate hospital outcomes and may stimulate a critical examination of current Canadian methods that compare length of stay by diagnostic label for different locations.

We agree that length of stay is contextual and that, consequently, comparisons must involve inappropriateness and not length of stay alone. Length of stay is a property of the patient, institution and community. If services are available in a community (and every hospital service can be made available in the community at a price) then days in hospital are reduced, but not necessarily costs.

An important implication in this article is that the "right" length of stay for a particular patient with a specific problem is determined by the way care is organized in a com-

munity. The same patient may require a 6-day stay in community A but only a 2-day stay in community B if services such as intravenous therapy are provided more efficiently outside of hospital in community B.

Our work at the Queen Elizabeth II Health Sciences Centre in Halifax shows that one can assess appropriateness and effectiveness while patients are in hospital. This concurrent review reduces the proportion of hospital days used by patients who do not require acute care services.

In order for physicians and administrators to collaborate, communities must articulate how they wish to provide care to those who need it. Patients and their families are concerned about health status, and physicians want to achieve this by the best application of resources. Concurrent review of both health status and care activities increases appropriateness of setting and services delivered by providing feedback that encourages collaboration and dialogue. When there is agreement about where services are best provided, concurrent review addresses the concerns expressed in Lavis and Anderson's article. It also provides an opportunity to develop information systems uniquely suited to Canadian health care.

**David Zitner, MA, MD, FCFP**

Medical quality improvement consultant  
**Donald F. Fay, PhD, PEng, MD**  
Co-chair  
Utilization Committee  
Queen Elizabeth II Health Sciences  
Centre  
Halifax, NS

#### [The authors respond:]

**D**rs. Zitner and Fay provide insights on the measurement and policy implications of the appropriateness of setting, one of the two types of appropriateness discussed in our article. They agree that we should build on simple assessments of hospital-based care, such as length